LOS ANGELES COUNTY COMMISSION ON HIV

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PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

August 12, 2014

PP&A MEMBERS PRESENT	PP&A MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Brad Land, *Co-Chair*	Al Ballesteros, MBA, *Co-Chair*	Aaron Fox	Jane Nachazel
Michelle Enfield	Lynnea Garbutt	Joseph Green	Craig Vincent-Jones, MHA
Abad Lopez	Sharon Holloway/Ismael Morales	Michael Pitkin	
Miguel Martinez, MPH, MSW	Marc McMillin	Terry Smith	
Juan Rivera/Rev. Alejandro Escoto, MA	Mario Pérez, MPH	Jason Wise	**DHSP STAFF**
Monique Tula	Sabel Samone-Loreca/Susan Forrest		Mike Janson, MPH
	LaShonda Spencer, MD		

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Planning, Priorities & Allocations (PP&A) Committee Meeting Agenda, *8/12/2014*
2) **PowerPoint**: Priority- and Allocation-Setting Training, FY 2015 Framework and Process, *6/12/2014*
3) **PowerPoint**: HIV Testing Services Overview, *8/12/2014*
4) **Report**: County of Los Angeles County, Department of Public Health, Division of HIV and STD Programs, 2011 Annual HIV Testing Report, *December 2013*
5) **Report**: County of Los Angeles HIV Care and Treatment Service Utilization, 2012 Year End Report, *April 2014*
6) **Table**: Planning, Priorities and Allocations Committee, FY 2014 Work Plan, *8/12/2014*
7) **Proposal**: Comprehensive HIV Planning Task Force, Description, *8/12/2014*

1. **CALL TO ORDER:** Mr. Land called the meeting to order at 1:25 pm.

2. **APPROVAL OF AGENDA:**
   MOTION #1: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES:**
   MOTION #2: Approve the Priorities and Planning (P&P) and Planning, Priorities and Allocations (PP&A) Committee meeting minutes, as presented **(*Postponed*)**.

4. **PUBLIC COMMENT *(Non-Agendized or Follow-Up)*:**
   - Mr. Pitkin requested clarification on conflict-of-interest. Mr. Vincent-Jones noted a detailed training was planned for September. HRSA defines conflict-of-interest as a representative of an agency with a contract for a service voting on financial measures pertaining to that service. Conflicts cannot all be eliminated, but there are mechanisms to address them, e.g., attendees list their conflicts prior to financial discussions.
   - Mr. Pitkin also asked about the Commission's Consent Calendar. Mr. Land replied the common mechanism saves time by allowing several motions to be approved at once. Anyone can pull a motion for later discussion at its regular agenda item.

5. **COMMITTEE COMMENT *(Non-Agendized or Follow-Up)*:**
   - Mr. Rivera expressed concern about an Office of AIDS (OA) letter on return to six-month ADAP certification. It is already hard to schedule a recertification appointment for consumers in his District 3 area so doubling enrollment workers' work can only make delays worse. Many of his pharmacy clients report clinics only provide ADAP enrollment for their own clients.

It was assumed the need for certified ADAP enrollment workers would decline as consumers migrated to Medi-Cal, but the decline is less than expected since many people with Covered California or private insurance still need ADAP help.

- Mr. Land said six-month recertification was delayed due to implementation, but remains a federal requirement. Mr. Vincent-Jones reported OA held off six-month recertification as long as possible and has worked with the community to streamline it. The Commission has also increased funding for Benefits Specialty which now includes ADAP enrollment.
- Mr. Fox noted OA said on a prior ADAP call that enrollment workers had to attend training in person to retain certification, but that was a misnomer. It caused concern as many workers would not have been able to leave work to attend.
- ➲ Mr. Fox said many consumers who recertified in April did not expect to recertify for a year. He will raise the issue of how to correct consumers' misperceptions with OA during the 8/14/2014 conference call to ensure recertifications are timely. He will also relay the need for additional ADAP funding to ensure sufficient staff.
- ➲ Mr. Vincent-Jones will follow-up with DHSP to ensure providers have been made aware that ADAP enrollment can be charged to Benefits Specialty. It was only added to that service category approximately 18 months ago.

6. **CO-CHAIRS' REPORT:** Mr. Land reported he and Mr. Ballesteros have asked Mr. Vincent-Jones to provide more context for agenda items to assist PP&A members, especially those new to the process, to understand and fully participate in discussions.

7. **SERVICE UTILIZATION REPORTS (SUR)**:

- Mr. Vincent-Jones said the HIV Care and Treatment SUR has historically provided the best data on how consumers access services to inform Priority- and Allocation-Setting (P-and-A). The Commission worked with DHSP to develop that SUR.
- The Commission will engage in prevention P-and-A for the first time this year. Prevention data will not be constructed in the same way. Discussions continue on what data will be the most helpful, but some was ready for presentation now.

A. HIV Counseling/Testing Service Utilization:

- Mr. Janson, Chief, Program Evaluation and Data Management, said DHSP has traditionally presented testing services in the Annual Report format which has been fairly static for up to eight years. Data collection on the HIV testing site has been dramatically streamlined over the past four to five years so some data elements may not be available.
- The Annual Report is normally published each year, but was delayed the last few years due to multiple factors. The 2011 Annual Report was published the prior week and Mr. Pérez was reviewing 2012. Release of the 2013 Annual Report was anticipated in October 2014. Consequently, much of the presentation data was not yet for public release.
- There was no Health Education/Risk Reduction (HH/RR) report due to collecting, processing and reporting challenges. DHSP most recently tried to collect process and outcome measures to evaluate service effectiveness in averting infection and other adverse outcomes, but data quality was poor. The best information was in CDC progress reports.
- Comparatively, testing data is likely the most accurate and timely in years, but HE/RR data is collected differently, e.g., testing is one event per person, but HE/RR uses three, six, nine or more sessions with 30-, 60- or 90-day follow-up per client. Linking sessions to gauge effectiveness is challenging as clients provide just initials and maybe a birth date at baseline. Much more data is collected for testing, e.g., first and last name, date of birth and Social Security Number.
- Capacity is also an issue. Testing programs increasingly use electronic records to capture information. On the other hand, nearly all HE/RR programs use paper records which make data more difficult to track.
- DHSP recently shifted to employing the CDC's online data collection system, Evaluation Web, with HE/RR providers directly reporting to the CDC. The change was in response to CDC pressure to report complete and accurate data and DHSP's challenges in HE/RR data collection, processing, management and reporting. DHSP will continue to monitor this new approach. DHSP continues to report its own testing data directly to the CDC.
- Mr. Vincent-Jones asked how prevention quality management compared to that for care and treatment. Mr. Janson replied there are multiple layers of prevention performance measure data questions. DHSP's Program Evaluation and Data Management Division addresses both prevention and care/treatment data which includes some overlap. PEP and PrEP data is reported as a separate program within testing.
- Ms. Tula asked if the County participates in CDC's Antiretroviral Treatment Access Study (ARTAS), a biomedical intervention for HIV treatment and prevention. Mr. Janson said DHSP uses ARTAS for linkage to and retention in care.
- Ms. Tula suggested funding providers for program evaluation and tying that to service provision. Mr. Janson replied evaluation tools were developed with the assumption that DHSP would evaluate data, but collecting the measures was difficult. Some ten years ago, HE/RR contracts included a provision that allowed providers to hire and pay for an evaluator for that part of the program, but it was unsuccessful. Mr. Martinez noted concepts of evaluation differed.
- Mr. Martinez added a separate evaluation contract was offered during the last RFP round, but there were no bidders.

- Mr. Vincent-Jones said the Commission could address evaluation as part of its charge to assess needs of consumers served by the system and ensure effective services. Data is a major issue including differences between care/treatment and prevention data and how the latter is collected. Mr. Smith noted it can be hard for HE/RR clients to complete forms, e.g., they may be sober for one session and not for another which often results in listing different birth dates.
- Mr. Land asked if PP&A could review the monthly HE/RR report. Mr. Janson replied it includes just a few process measures, but DHSP could share them. The CDC report is a summary of provider data, e.g., number of people seen. HE/RR reporting is now in transition to CDC's Evaluation Web. Transition results should be available in six to 12 months.
- Mr. Smith said the prevention environment is also shifting with a move away from groups to testing, biomedical interventions, linkage to and retention in care. Mr. Land noted the Commission still needs to understand how to address allocations that provide stability for consumers as the transition progresses.
- Ms. Tula felt the HIV prevention subject was broader than PP&A so the discussion should start at that broader level with data returned to PP&A to inform the P-and-A process.
- Mr. Janson reported County HIV testing was dramatically revised in 2011 including several new programs. One of these programs was a Pay-For-Performance (PFP) model with four key measures: testing volume, new positivity rate, referral to other services and linkage to care. PFP significantly improved data submission timeliness and accuracy. Previously, data was submitted 30 days to six months post-test including data for HIV+ tests. Now data is submitted in 7 days.
- HIV+ tests are classified by: HIV+, which includes all HIV+ tests; new HIV+ by self-report, for which the client indicates s/he has not previously tested HIV+; and new HIV+, for which tests are matched against surveillance data to confirm no prior HIV+ test. Data reflects notable differences among the categories, e.g., of 137,363 HIV tests in 2013: 1,310 were HIV+, 1,123 were self-reported new HIV+, but only 974 were confirmed HIV+ for a final positivity rate of 0.71%.
- The 2013 positivity rate for new HIV+ by self-report was 0.82%. DHSP currently uses a 1.03% HIV+ by self-report rate as the contract benchmark which most providers are currently meeting. The CDC target positivity rate is 2.0%.
- Mr. Vincent-Jones asked if DHSP had considered focus groups to identify why people report they are newly HIV+ when they have tested HIV+ previously. Mr. Janson reported DHSP has done several analyses on those who have retested multiple times. Over 85% of those who retested despite knowing their status had been out of care for six months or more. That suggests the population is using testing as a means to re-engage in care.
- Mr. Smith added some people also test for incentives. He felt tests had increased post-PFP, but the positivity rate declined. Mr. Janson replied the 2013 rate was lower, but overall the rate has been relatively stable including for 2014.
- The DHSP partner services referral benchmark is 100% while results have been somewhat less than that at 82% to 87% per year. Linage to care for clients with HIV+ tests has increased significantly from 67% in 2010 to 85.7% in 2013.
- Testing volume has increased since 2000 with accelerated increases starting in 2009 with the debut of routine testing in medical settings and continuing with New Directions in 2011. 2014 will likely reflect a slight dip. The positivity rate has remained stable with most newly diagnosed people testing HIV+ at STD clinics or storefront HIV testing sites.
- The CDC is pleased with increased diagnoses post-PFP implementation. Hybrid contracts use 60% cost reimbursement and 40% based on the four measures. DHSP has provided technical assistance to other jurisdictions on the model.
- The HIV Testing Services by Modality and Program Type table shows positivity rates vary markedly among modalities and programs. Targeted testing with 580 of 857 confirmed new HIV+ tests shows a high positivity rate at 0.72% with storefront testing reporting 382 tests at a 0.84% rate and mobile units reporting 154 at a 0.51% rate. The other major contributor to new HIV+ test data was routine testing at community STD clinics with 184 reported at a 2.36% rate.
- DREX, a drug treatment program at drug testing and treatment facilities, had minimal testing and was phased out.
- The social network program began as a pilot some five years ago with small incentives for PLWH to recruit their sexual or social contacts with additional small incentives for each person recruited. Initially it had an 8.0% positivity rate. It has primarily been in the Hollywood area and targeted MSM who are drug users, transgender or homeless. The rate has dropped each year and is now approximately 2.0% so there was a question of whether saturation has been reached.
- Mr. Vincent-Jones asked about Emergency Rooms (ERs). Mr. Janson said LAC+USC Medical Center is the sole ER using routine testing. DHSP identified LAC+USC based on cluster analysis of new diagnoses and recommended an opt out screening model. LAC+USC identified six pods that provided a minimum patient stay of four hours and clinic flow, e.g., a research assistant does linkage and follow-up. Testing has doubled since 2012 and the positivity rate is up to 0.6%.
- In 2013, the overall positivity rate dropped from 1.14% to 0.95% marking the first time it had dropped below 1.0%. There was a significant drop in the mobile rate from 0.93% to 0.57%. It is possible providers were attempting to increase volume, a performance measure. DHSP has clarified expectations on volume in relation to identifying new positives and their referral and linkage to care. DHSP also provided additional geographic targeting tools because evaluation of mobile testing indicated some sites had a greater than 1.0% rate while others had rates as low as 0.1%.

- From 2012 to 2013, social network confirmed new HIV+ tests have increased from 8 to 35 and the positivity rate from 0.68% to 2.96% with a linkage to care rate up dramatically from 73.2% to 92.7%.
- Overall, linkage to care has increased from 78.0% in 2012 to 85.7% in 2013 which outperforms other jurisdictions. Surveillance data indicates that other providers such as Kaiser did not experience a similar increase.
- Mr. Vincent-Jones asked about overall opt out data. Mr. Janson said DHSP has influence with many programs such as those reflected under targeted testing and jails because it has contracts with them. LAC+USC also shares data. Often DHSP only provides test kits for routine testing at other providers as well as technical assistance in some cases.
- Since the revised testing program is relatively new, it is hard to gauge how to set a realistic overall positivity rate target. DHSP is working with the CDC to identify the target. Overall, the rate is now approximately 1.0%. DHSP's emphasis is not testing just to test, but to focus on an increased positivity rate, referrals and especially linkage as emphasized in the RAND analysis. It is more cost effective to link a previously tested HIV+ person to medical care than to link the person through a redundant test at a test site. Any needed confirmatory test can be done at the HIV medical care provider.
- Mr. Vincent-Jones asked if DHSP evaluates factors besides the geographic such as correlations with STDs and poverty. Mr. Janson noted a significant correlation with syphilis and to a lesser extent gonorrhea. DHSP reviews multiple factors in highly impacted areas, e.g., poverty is highly correlated in Central and South Los Angeles, but not in West Hollywood. Mr. Vincent-Jones said the Commission could assist DHSP in identifying the most effective testing sites.
- ➲ Agendize data discussion for the January PP&A meeting along with the CDC report.
- ➲ The Commission, including the Comprehensive HIV Planning Task Force, and DHSP, including Mr. Janson or a Program Evaluation and Data Management Division representative, will collaborate on developing a possible task force to address prevention evaluation including data collection issues.
- ➲ Mr. Janson will forward data on those who have retested regularly to Mr. Vincent-Jones.
- ➲ Mr. Janson will provide data on the newly diagnosed including cluster analysis.
- ➲ Mr. Janson will update 2013 data to include APLA's CHRP program under storefront. CHRP began in 2013.

B. **2012 HIV Care/Treatment Service Utilization**: There was no additional discussion.

8. FY 2015 PRIORITY- AND ALLOCATION-SETTING (P-and-A) OVERVIEW:

A. FY 2015 Baseline Allocations:

- Mr. Vincent-Jones noted the Commission approved using FY 2014 allocations as the baseline for FY 2015. Residential Services costs were also shifted from Net County Cost (NCC) to Ryan White (RW) Part B to maximize Part B and free NCC funds for PEP and PrEP. Now, however, NCC will need to assume a larger than anticipated amount of legal costs.
- That leaves PEP and PrEP unfunded with little time to determine a funding strategy and develop contracts since RW FY 2015 starts 3/1/2015, the CDC grant starts 1/1/2015 and NCC FY 2015 already began on 7/1/2015.
- Mr. Land suggested recommending DHSP allocate FY 2015 NCC funds for biomedical interventions and advocate for that to the Board. Mr. Vincent-Jones said that was feasible, but there are two new lawsuits. County Counsel does not advise departments of its approved costs until year end so DHSP was unaware. It could only offer estimates until then.
- Mr. Ballesteros said the motion freeing NCC funds for biomedical interventions included a report back from DHSP on an implementation plan. Instead, DHSP reported increased legal costs. There is still no plan regardless of funding.
- Ms. Tula felt much of the frustration is due to lack of a more authentic conversation on costs. Legal costs do need to be paid, however reluctantly, but the Commission could well have voted differently with a more accurate NCC assessment.
- Mr. Vincent-Jones noted the Commission controls RW Part A/B and CDC funds, but not NCC. A previous motion that supported a shift of NCC costs to RW included a contingency that required DHSP to maintain the same level of care and treatment funding in order to transfer the funds. This latest motion did not.
- Mr. Smith noted DHSP had identified $1 million in legal costs, but then County Counsel presented it with a bill for &1.8 million at the end of June. He felt DHSP and the Commission were working towards the same goal. We should say that. We should also understand the challenges in getting PEP/PrEP on the street and advocate to the Board to meet those challenges, e.g., it may well require a sole source contract to implement in a timely manner.
- Mr. Vincent-Jones noted the Commission lacks authority for final allocation of NCC funds, but can advise the Board that the situation is unfair and advocate for an NCC increase to compensate for increased legal costs while maintaining intended funds for PEP/PrEP. The Board has increased NCC in the past to meet increased nursing contract costs.
- He reminded the body that no PEP/PrEP funds had yet been identified for RW FY 2014.

- Regarding PEP/PrEP implementation, any attempt to use a sole source contract would likely be met with a lawsuit and the courts commonly halt services while such a suit is litigated. Mr. Martinez pointed out Mr. Pérez reported DHSP is still developing a PEP/PrEP service plan. Much of it might be supportable through existing services.
- Ms. Tula reported the CDC is about to release its FOA for directly funded prevention programs. PrEP may be included. She was concerned with the risk of a lawsuit over sole source. Instead, groundwork could be funded with NCC.
- Mr. Smith said biomedical interventions are now available in South Los Angeles and Hollywood. A public health case can be made for countywide expansion. Ms. Tula noted needle exchange was funded as a public health emergency.
- Mr. Rivera reported PEP/PrEP is already prescribed by many private physicians using CDC guidance and funded with existing insurance. In fact, some physicians have bolstered their practices by developing a reputation as "PEP/PrEP friendly." The Commission can expand capacity by educating physicians on use of existing insurance options, e.g., Medi-Cal covers it and so do many Covered California plans with a prior authorization that takes approximately two weeks.
- The remaining PEP/PrEP service gap would be for the uninsured and/or undocumented. Work could continue to resolve how to provide services for that population while developing increased capacity for other populations.
- Mr. Land suggested tying the recommendation to the Board for increased NCC funding to PEP/PrEP services. Mr. Vincent-Jones replied that would tie the Commission to a strategy which is unnecessary and may or may not be useful.
- Ms. Tula felt Board advocacy should stress the ongoing public health emergency especially among MSM of color. The Commission and DHSP are partners and ongoing legal costs must be paid, but not by ignoring the emergency. Mr. Vincent-Jones said key points are the public health emergency and that DHSP should not need to pay legal costs alone.
- Mr. Smith urged more effective public engagement on this issue from a public health perspective. Mr. Vincent-Jones said the Public Policy Committee was developing a strategy that can be used to support a consistent message.
- Mr. Martinez felt it unnecessary to do everything at once making the revision unnecessary. Mr. Vincent-Jones noted the revision addresses a baseline for FY 2015 CDC allocations which was left out of the prior motion.
- It also addresses Mr. Pérez's original commitment to provide a PEP/PrEP plan in light of new information on legal costs. It stresses the Commission's concern for PEP/PrEP funding while committing to Board advocacy for additional funds without asserting NCC fund allocations which is not within the Commission's purview. It can be revised at the meeting.
- Mr. Vincent-Jones will draft a revised iteration of the Commission's 8/7/2014 motion to extend FY 2014 allocations as a baseline for FY 2015 allocations to better accomplish Commission goals and would email the written draft to PP&A that night for a yes/no response. (The Brown Act precludes discussion by a quorum of a body by email.) Key points are:
    1. Extend FY 2014 RW and CDC allocations to use as baseline allocations for their respective years beginning in 2015 with the proviso that the Commission requests from DHSP possible solutions for moving current CDC commitments in 2015 to allow for additional expenditures for PEP, PrEP and biomedical interventions;
    2. Ask DHSP to present ways they can ensure if CDC funds are not used for this purpose that NCC funds can be guaranteed for this purpose; DHSP will be expected to act on that point at a subsequent Commission meeting;
    3. Ask DHSP to present possible solutions for extending PEP and PrEP in FY 2014;
    4. The Commission will advocate for the Board of Supervisors to increase the NCC share that the Department of Public Health receives.

B. **The Role of the Comprehensive HIV Plan (CHP) in P-and-A**: Mr. Land reported the Comprehensive Planning Task Force completed its task descriptions as noted in the packet summary. Tasks are: 1. Update 2013 Comprehensive HIV Plan; 2. Coordinate 2014 Annual Meeting; 3. Coordinate 2014 Annual Report to Board.

C. **Review of P-and-A Steps**: This item was postponed.

9. NEXT STEPS: This item was postponed.

10. ANNOUNCEMENTS: There were no announcements.

11. ADJOURNMENT: The meeting adjourned at 4:25 pm.